Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan C: Mental Health/Substance Abuse Medical Home Pilot
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.
- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.
- An individual entitled to benefits under any part of Medicare.
- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	FFS individuals with a diagnosis of a serious	Pilot areas to be determined

			mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
	X	Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation	FFS indivi-duals with a diagnosis of a	Pilot areas to be determined

		from the Social Security Act for each eligibility group: • SSI Recipients • 1902(a)(10)(A)(i)(I)	serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	FFS indivi-duals with a diagnosis of a serious mental illness	Pilot areas to be determined

			or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	X	Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI-related • • •	FFS indivi-duals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more	Pilot areas to be determined

			hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalize-tions or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations	Pilot areas to be determined

		or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
X	Individuals qualifying for Medicaid on the basis of blindness	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals qualifying for Medicaid on the basis of disability	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the	Pilot areas to be determined

		following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Disabled children eligible under the TEFRA option - section 1902(e)(3)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined

X	Medically frail and individuals with special medical needs	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
	Children receiving foster care or adoption assistance under title IV-E of the Act		
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency	Pilot areas to be determined

		room visits in the past 12 months; or other key risk factors developed by the DHS.	
X	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)	FFS individuals with a diagnosis of a serious mental illness or substance use disorder with the following risk factors: 2 or more hospitalizations or emergency room visits in the past 12 months; or other key risk factors developed by the DHS.	Pilot areas to be determined

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,

- The individual was given ample time to arrive at an informed choice,
- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

When comparing all diseases, mental illnesses rank first in terms of causing disability in the United States. Mental health disorders are an enormous social and economic burden to society by themselves, but are also associated with increases in the risk of physical illness. More specifically, mental health disorders are associated with increased rates of chronic health problems and risk factors such as smoking, physical inactivity, obesity, and substance abuse and dependence. Among Wisconsin adults, the burden of chronic physical disease falls heavily on those with mental health problems, as evidenced by comparatively higher rates of cardiovascular disease and diabetes. Individuals with serious mental illnesses and substance use disorders often find it difficult to manage the primary health care system due to the symptoms of their illness and receive care only at the point of a health care crisis which results in poor health care outcomes and increased cost to the health care system.

The Mental Health and Substance Abuse Medical Home will initially pilot a medical home to enroll fee-for-service individuals who have a serious mental illness or substance use disorder that experience risk factors such as two or more hospitalization or emergency room visits in the past year or other risk factors to be developed, into the Mental Health and Substance Abuse Medical Home Alternative Benchmark Plan C. This plan includes the full benefit package under the Medicaid/Standard Package but adds additional components that are critical for this vulnerable population with emphasis on the health care and behavioral health coordination thru a Medical Home and other additional services. The program will operate on an all in/opt out model. The participants will have the option of disenrolling after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will hold information sharing meetings with consumer groups, counties, tribes, mental health and substance abuse providers, and established community and advocacy groups.

   These sessions will serve as a forum for the state to explain the new benefit, respond to questions, and to solicit feedback on its outreach strategies.

2. The state will meet with Tribal representatives to discuss the program as it affects persons who are identified as American Indian and Alaskan Native and will obtain their recommendations.

3. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process.
   c. Clearly inform individuals and families that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a person-centered and recovery based multi-disciplinary treatment plan that addresses access and coordination across the full spectrum of the individual's needs – from preventive services and health screenings, to specialty medical care, inpatient care, and community treatment services.
   e. Provides a toll-free contact number for questions and information.

4. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights to individuals and families.
   b. Informing individuals and families about the voluntary nature of the program, including how to discontinue their participation.
   c. Letting individuals and families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating individuals and families about the benefits of participating in this program, for example, improved communication and coordination between health care providers and the individuals and their family.
   e. Documenting all requests for disenrollment.

5. The state will make direct mailings to individuals and families informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

6. The state will send written notification to the individual or family regarding all disenrollments. The notification to the individual or family will explain that the individual's regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the individual or family have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.
- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.
- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.
- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.
- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.
- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.
- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of individuals with serious mental illnesses and substance use disorders. A key component is health care coordination, including: (a) medical care plan development that addresses physical, dental and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation including outcome measures. The intention is to link participants to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and increased effectiveness of health and related healthcare services. The medical care will be person-centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to individuals with serious mental health and substance use disorders.;
b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of individuals with serious mental health and substance use disorders. The team identifies the health needs of each individual, creates a care plan, and ensures that each individual is assigned a care coordinator;
c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
d. Services provided through open and flexible scheduling;
e. Comprehensive transitional care as the individual moves from one setting to another;
f. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of individuals with serious mental illnesses and substance use disorders and on comprehensive care coordination, will assure a person-centered, recovery focus and continuity of care. The care coordinators will collaborate with the individual and/or family to identify providers who are experienced in meeting the needs of this population. The medical home must work with counties and tribes in their service area to assure seemless coordination and referral services. A more streamlined prior authorization process will apply with respect to mental health and substance abuse services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure services under EPSDT based on best practices and each child's needs, including:

a. Timely and trauma-informed screening, assessment and referral, including comprehensive mental health screening;
b. Evidence informed and comprehensive interventions in children's mental and behavioral health;
c. Mobile response and stabilization services;
d. Oversight of psychotropic medication, including pharmacist consultant services;
e. Enhanced schedule for physical, behavioral and dental care as necessary.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent

coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x□ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Individuals with serious mental illnesses and substance use disorders often have difficulty accessing appropriate medical and behavioral health care in the Medicaid fee-for-service delivery system. Medical and behavioral care is often fragmented, with no overall care coordination. In addition, many individuals with serious mental illnesses and substance use disorders have involved medical and behavioral health needs and often lack an accessible, adequately documented medical history. This plan provides care coordination and enhanced services for individuals in fee-for-service Medicaid with serious mental illnesses and substance use disorders with significant risk factors living in pilot areas of the state. The services and supports will follow the best evidence-based approaches and protocols for people with serious mental illnesses and substance use disorders as appropriate. The plan includes all benefits, including EPSDT, under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these individuals:

- A medical home framework specific to individuals with serious mental illnesses and substance use disorders;
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each individual;
- Individualized wellness plan and support to promote healthy behaviors, including but not limited to: smoking or tobacco use cessation, appropriate nutrition and exercise, support for behavioral interventions for depression, risky drinking or drug use.
- Comprehensive care coordination services bringing together the health and behavioral health needs of the individual;
- Peer and recovery support services;
- Substance Abuse Residential Treatment services;
- Short Term Residential Support services;
- Access to Urgent Care psychiatric and mental health treatment services in the community (access 24 hours a day/7 days a week);
- Medication utilization management
- Medication assisted treatment for substance use disorders

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date)*.

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older

- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program
- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services

DRAFT CJ Preprint v. 1.3
UPDATED 10/20/11

Attachment 3 – Services: General Provisions

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan E: Medical Home Pilot for Persons with Severe Mental Illness Leaving Criminal Justice and Mental Health Institutes
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible f Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;

- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;
- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	X	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	X	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI Recipients • 1902(a)(10)(A)(i)(I)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health	Pilot areas to be determined.

			Institutes	
	X	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	X	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
		Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI-related •	MA eligible persons with mental illness and chronic health conditions placed in	Pilot areas to be determined.

		• •	communities under supervision after leaving prisons and Mental Health Institutes	

X (ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
X	Mandatory categorically needy low-income parents eligible under 1931 of the Act	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):		
X	Individuals qualifying for Medicaid on the basis of blindness	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
X	Individuals qualifying for Medicaid on the basis of disability	MA eligible persons with	Pilot areas to be determined.

		mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	
X	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Institutionalized individuals assessed a patient contribution towards the cost of care		
X	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
X	Medically frail and individuals with special medical needs	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after	Pilot areas to be determined.

		leaving prisons and Mental Health Institutes	
	Children receiving foster care or adoption assistance under title IV-E of the Act		
X	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
X	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	MA eligible persons with mental illness and chronic health conditions placed in communities under supervision after leaving prisons and Mental Health Institutes	Pilot areas to be determined.
	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)		

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the mann in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

This medical home targets individuals eligible for Medicaid who are exiting the criminal justice system and mental health institutes.

Many of these individuals may have chronic conditions like asthma, diabetes or heart conditions that which need care coordination services to improve health outcomes. Individuals with serious mental illnesses and substance use disorders often find it difficult to manage the primary health care system due to the symptoms of their illness and receive care only at the point of a health care crisis which results in poor health care outcomes and increased cost to the health care system.

This medical home alternative benchmark plan targets three sets of individuals:

1) those eligible for Wisconsin Medicaid who have major mental illness and are placed in the community under supervision after leaving prisons and Mental Health Institutes
2) those eligible for Wisconsin Medicaid who have multiple chronic health conditions who are exiting the prison system

3) Medicaid Eligible individuals who are participants in either of the two following programs and placed within communities in the SE Region of the State:
    a. The Department of Health Services' Conditional Release Program. The Conditional Release Program funds mental health services for indigent persons who are committed as Not Guilty By Reason of Mental Disease or Defect (NGI) and are subsequently conditionally released by the court to the community. Examples of the types of services that the Department is authorized by statute to fund include: mental health medications, counseling, community support program services, residential placement costs - including community based residential facilities and alcohol and other drug abuse (AODA) outpatient treatment.
    b. The Department of Corrections' Opening Avenues to Re-entry Success (OARS) Program. This program, which works through a partnership with the Department of Health Services, targets inmates with severe and persistent mental illness who are at a medium to high risk of having their parole revoked. These are inmates who have reached their Mandatory Release date from prison and must be released to the community on parole.

Persons participating in the Conditional Release and OARS Programs may be eligible for Wisconsin Medicaid as a result of membership in a variety of eligibility groups. What the individuals have in common is involvement in the criminal justice system and severe mental illness. To maximize the coordination of critical medical and behavioral health needs with the other essential supports available to this population under the Conditional Release and OARS Programs, all eligible participants will initially be enrolled in the alternative benchmark program.

This program includes the full benefit package under the Medicaid/Standard Package but adds benefits critical for this vulnerable population – care coordination, medical assessments, and medication therapy management. The program will operate on an all in/opt out model. The member will have the option of disenrolling from the medial home after six months of continuous enrollment.

This plan includes the full benefit package under the Medicaid/Standard Package and adds health care coordination and other additional services. The program will operate on an all in/opt out model. Participants will have the option of disenrolling after six months.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will meet with Tribal representatives to discuss the program as it affects persons who are identified as American Indian and Alaskan Native and will obtain and follow their recommendations.

2. The state will develop informing materials that:

    a. Identify the geographic area and the population to be enrolled in the program.
    b. Explain the nature of the voluntary enrollment, including the period of enrollment, exemption criteria, and the opt-out process.
    c. Clearly inform individuals and families that participation in the program will not reduce their regular benefit package under Medicaid.
    d. Explain the benefits of the enhanced services, including having a person-centered and recovery based multi-disciplinary treatment plan that addresses access and coordination across the full spectrum of the individual's needs – from preventive services and health screenings, to specialty medical care, inpatient care, and community treatment services.

e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the staff of Criminal Institutions and Mental Health Institutes from which individuals are released to include outreach and information sharing to this population. These staff will be responsible for the following:

   a. Informing eligible individuals, in writing about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.
   b. Informing eligible individuals about how to discontinue their participation.
   c. Letting individuals and families know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
   d. Educating eligible individuals and families about the benefits of participating in this program, including improved communication and coordination between all health care providers.
   e. Documenting all requests for disenrollment.

4. In the case of a request for disenrollment, the state will send written notification to the participant and inform the health care coordinator and case manager. The notification will explain that disenrollment from the alternative benchmark plan will not end the individual's eligible for Wisconsin Medicaid. The state will include the number for the staffs described above who are responsible for communicating information on enrollment and disenrollment, should there be follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,

- The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan covers all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of individuals with severe and persistent mental illness and those with chronic health conditions. A key component is health care coordination, including: (a) medical care plan development that addresses physical and behavioral health needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation including outcome measures. The intention is to link participants with identified health physical and mental health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be person-centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

    a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to individuals with severe and persistent mental illness;
    b. Coordination of health care through a multidisciplinary team, including the primary care physician, that works to identify and meet the medical needs of individuals with serious mental illness. The team identifies the health needs of each individual, creates a care plan, and ensures that each individual is assigned a care coordinator;
    c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), chronic care and other specialty care, including relevant services provided through the Conditional Release and OARS Programs;
    d. Services provided through open and flexible scheduling;
    e. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of individuals with severe and persistent mental illness and on comprehensive care coordination, will assure a person-centered, recovery focus and continuity of care. The Care Coordinator will collaborate with the case manager in the Conditional Release or OARS program to identify providers who are experienced in meeting the needs of this population. A more streamlined prior authorization process will apply with respect to mental health and substance abuse services. The plan will attract providers by allowing enhanced, flexible services.

3. Providers will be required to ensure medical and behavioral health services based on best practices, including:

    a. timely and comprehensive behavioral screening (SBIRT, depression screening, tobacco screening, and trauma screening) and assessment;
    b. evidence informed and comprehensive interventions in mental and behavioral health;

c. mobile response and stabilization services;
d. oversight of psychotropic medication, including pharmacist consultant services;
e. enhanced schedule for physical and behavioral health care as necessary.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;

- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

This plan provides care coordination and enhanced services for individuals with serious mental illnesses living in the pilot area. The services and supports will follow the best evidence-based approaches and protocols for people with serious mental illnesses and chronic health conditions as appropriate. The plan covers all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and critical needs of these individuals:

- A medical home framework specific to individuals with serious mental illnesses and criminal justice history;
- Comprehensive medical assessment and treatment, including for behavioral health, based on best practices and the needs of each individual;

- Individualized wellness plan and support to promote healthy behaviors, including but not limited to: smoking cessation, appropriate nutrition and exercise, support for behavioral interventions for depression, risky drinking and drug use.
- Enhanced patient education to include:
  - Self-management
  - Health education services
  - Nutritional counseling from dieticians
- Comprehensive care coordination services bringing together the health and behavioral health needs of the individual;
- Peer and recovery support services;
- Substance Abuse Residential Treatment services;
- Short Term Residential Support services;
- Access to Urgent Care psychiatric and mental health treatment services in the community (access 24 hours a day/7 days a week);
- Medication utilization management
- Medication assisted treatment for substance use disorders
- Any additional care coordination services needed to address the complex needs associated with this population.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date)*.

3.1-C. Benchmark Benefit Package and Benchmark Equivalent Benefit Package (provided in accordance with 1937 of the Act and 42 CFR Part 440).

The State/Territory provides benchmark benefits:

X Provided

☐ Not Provided

States/Territories can have more than one alternative/benchmark benefit plan for different individuals in the new optional group. If the State/Territory has more than one alternative benefit plan, as in the example below, then a pre-print would need to appear for each additional Benchmark Plan title. (Ex: if the box signifying "Plan A" was checked then the remainder of the pre-print that would appear would be specific only to "Plan A". If "Plan B" was checked then the following pre-print that would appear would be a completely new pre-print that would be filled out by the State/Territory and would correlate to "Plan B" only.)

☐ Title of Alternative Benefit Plan A BadgerCare Plus Benchmark
X Title of Alternative Benefit Plan D: Medical Home Pilot for Persons with Chronic Conditions
☐ Add Titles of additional Alternative Benefit Plans as needed

1. Populations and geographic area covered

X **a) Individuals eligible under groups other than the early option group authorized under section 1902(a)(10(A)(i)(VIII) and 1902(k)(2)**

The State/Territory will provide the benefit package to the following populations:

X (i) Populations who are full benefit eligibility individuals in a category established on or before February 8, 2006, who will be required to enroll in an alternative benefit plan to obtain medical assistance.

Note: Populations listed below may not be required to enroll in a benchmark plan. The Benchmark-exempt individuals under 1937(a)(2)(B) are:

- A pregnant woman who is required to be covered under the State/Territory plan under section 1902(a)(10)(A)(i) of the Act.

- An individual who qualifies for medical assistance under the State/Territory plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for Supplemental Security Income benefits under title XVI on the basis of being blind or disabled and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3) of the Act.

- An individual entitled to benefits under any part of Medicare.

- An individual who is terminally ill and is receiving benefits for hospice care under title XIX.

- An individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and is required, as a condition of receiving services in that institution under the State/Territory plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

- An individual who is medically frail or otherwise an individual with special medical needs. For these purposes, the State/Territory's definition of individuals who are medically frail or otherwise have special medical needs must at least include those individuals described in 42 CFR §438.50(d)(3), children with serious emotional disturbances, individuals with disabling mental disorders, individuals with serious and complex medical conditions, and individuals with physical and or mental disabilities that significantly impair their ability to perform one or more activities of daily living.

- An individual who qualifies based on medical condition for medical assistance for long-term care services described in section 1917(c)(1)(C) of the Act.

An individual with respect to whom child welfare services are made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of title IV, without regard to age.

- A parent or caretaker relative whom the State/Territory is required to cover under section 1931 of the Act.

- A woman who is receiving medical assistance by virtue of the application of sections 1902(a)(10)(ii)(XVIII) and 1902(aa) of the Act.

- An individual who qualifies for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XII) of the Act.

- An individual who is only covered by Medicaid for care and services necessary for the treatment of an emergency medical condition in accordance with section 1903(v) of the Act.

- An individual determined eligible as medically needy or eligible because of a reduction of countable income based on costs incurred for medical or other remedial care under section 1902(f) of the Act or otherwise based on incurred medical costs.

For full benefit Medicaid eligibility groups included in the alternative benefit plan, please indicate in the chart below:

- Each eligibility group the State/Territory will require to enroll in the alternative benefit plan;
- Each eligibility group the State/Territory will allow to voluntarily enroll in the alternative benefit plan;

- Specify any additional targeted criteria for each included group (e.g., income standard);
- Specify the geographic area in which each group will be covered.

Required Enrollment	Opt-In Enrollment	Full-Benefit Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	x	Mandatory categorically needy low-income families and children eligible under section 1925 for Transitional Medical Assistance	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Mandatory categorically needy poverty level infants eligible under 1902(a)(10)(A)(i)(IV)		
		Mandatory categorically needy poverty level children aged 1 up to age 6 eligible under 1902(a)(10)(A)(i)(VI)		
		Mandatory categorically needy poverty level children aged 6 up to age 19 eligible under 1902(a)(10)(A)(i)(VII)		
	x	Other mandatory categorically needy groups eligible under 1902(a)(10)(A)(i) as listed below and include the citation from the Social Security Act for each eligibility group: • SSI recipients • 1902(a)(10)(A)(i)(I) • •	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more	Pilot area to be determined

			ER visits or 1 hospitalization in past 2 years	
	x	Optional categorically needy poverty level pregnant women eligible under 1902(a)(10)(A)(ii)(IX)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Optional categorically needy poverty level infants eligible under 1902(a)(10)(A)(ii)(IX)		
	x	Optional categorically needy AFDC-related families and children eligible under 1902(a)(10)(A)(ii)(I)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
		Medicaid expansion/optional targeted low- income children eligible under 1902(a)(10)(A)(ii)(XIV)		
	X	Other optional categorically needy groups eligible under 1902(a)(10)(A)(ii) as listed	Adult FFS BadgerCare	Pilot area to be

		below and include the citation from the Social Security Act for each eligibility group: • SSI-related • • •	Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	determined

(ii) The following populations will be given the option to voluntarily enroll in an alternative benefit plan. Please indicate in the chart below:

- Each population the State/Territory will allow to voluntarily enroll in the alternative benefit plan,
- Specify any additional targeted criteria for each included population (e.g., income standard).
- Specify the geographic area in which each population will be covered.

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
x	Mandatory categorically needy low-income parents eligible under 1931 of the Act	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Mandatory categorically needy pregnant women eligible under 1902(a)(10)(A)(i)(IV) or another section under 1902(a)(10)(A)(i):	Adult FFS BadgerCare Plus and SSI population with	Pilot area to be determined

		two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	
x	Individuals qualifying for Medicaid on the basis of blindness	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals qualifying for Medicaid on the basis of disability	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined

x	Individuals who are terminally ill and receiving Medicaid hospice benefits under 1902(a)(10)(A)(ii)(vii)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
	Institutionalized individuals assessed a patient contribution towards the cost of care		
x	Individuals dually eligible for Medicare and Medicaid (42 CFR §440.315)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
	Disabled children eligible under the TEFRA option - section 1902(e)(3)		
x	Medically frail and individuals with special medical needs	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart	Pilot area to be determined

		conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	
	Children receiving foster care or adoption assistance under title IV-E of the Act		
x	Women needing treatment for breast or cervical cancer who are eligible under 1902(a)(10)(A)(ii)(XVIII)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals eligible as medically needy under section 1902(a)(10)(C)(i)(III)	Adult FFS BadgerCare Plus and SSI population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	Pilot area to be determined
x	Individuals who qualify based on medical condition for long term care services under 1917(c)(1)(C)	Adult FFS BadgerCare Plus and SSI	Pilot area to be determined

		population with two or more chronic conditions such as asthma, diabetes, heart conditions but excluding mental health comorbidities; and 2 or more ER visits or 1 hospitalization in past 2 years	

Limited Services Individuals

Opt-In Enrollment	Included Eligibility Group and Federal Citation	Targeting Criteria	Geographic Area
	TB-infected individuals who are eligible under 1902(a)(10)(A)(ii)(XII)		
	Illegal or otherwise ineligible aliens who are only covered for emergency medical services under section 1903(v)		

X (iii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe in the below the manner in which the State/Territory will inform each individual that:

- Enrollment is voluntary;
- Each individual may choose at any time not to participate in an alternative benefit package and;
- Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

A medical home targeting adult Fee-For-Service BadgerCare Plus and SSI members with multiple chronic conditions like asthma, diabetes or heart conditions (excluding mental health comorbidities) will enable this vulnerable population to receive the care coordination services they greatly need to improve health outcomes. To maximize the benefits of the medical home and ensure the immediate medical assessment and care needs of members are addressed, this program will initially enroll all eligible members into the alternative benchmark program. This program includes the full benefit package under the Medicaid/Standard Package but adds benefits critical for this vulnerable population – care coordination, medical assessments, and medication therapy management. The program will operate on an all in/opt out model. The member will have the option of disenrolling from the medial home after six months of continuous enrollment.

Wisconsin will use different avenues to inform each individual about their rights under this program. Below are some of the ways in which the state plans to inform individuals, Tribal governments, advocates, and the community about the program:

1. The state will hold meetings with Tribal representatives to obtain their recommendations.

2. The state will develop informing materials that:

   a. Identify the geographic area and the population to be enrolled in the program.
   b. Explain the nature of the **voluntary** enrollment, including the period of enrollment, exemption criteria, and the opt-out process
   c. Clearly inform members that participation in the program will not reduce their regular benefit package under Medicaid.
   d. Explain the benefits of the enhanced services, including having a care plan that is multi-disciplinary; addresses access and coordination across the full spectrum of the patient's needs – from preventive services and health screenings, to specialty medical care, inpatient care, and crisis intervention.
   e. Provides a toll-free contact number for questions and information.

3. The state will expand the duties of the Medicaid HMO Enrollment Specialist to include outreach and information sharing to this population. The Enrollment Specialist will be responsible for the following:

   a. Answering questions and providing information via the toll-free line, including explaining the enrollment procedures and member rights.
   b. Informing members about the voluntary nature of the program, including how to discontinue their participation.

c. Letting members know that there is no cost or reduction of benefits; emphasizing the fact this benefit is offered in addition to the full complement of services already covered under Wisconsin Medicaid.
d. Educating members about the benefits of participating in this program, for example, improved communication and coordination between health care providers and the member.
e. Documenting all requests for disenrollment

4. The state will make direct mailings to members informing them about their enrollment in the program, the period of enrollment, the benefits of the program, and that they will have the option of disenrolling after the first six months.

5. The state will send written notification to the member and inform the health care coordinator of all disenrollments. The notification will explain that the regular benefit package will remain unchanged. The state will include the number for the Enrollment Specialist, should the member have follow-up questions.

☐ **b) Individuals eligible under the early option group authorized under sections 1902(a)(10)(A)(i)(VIII) and 1902 (k)(2)**

Note: Individuals in the early option group who are exempt from mandatory enrollment in Benchmark coverage under 1937(a)(2)(B) CANNOT be mandated into a Benchmark plan. However, State/Territories may offer exempt individuals the opportunity to voluntarily enroll in the Benchmark plan.

☐ (i) The State/Territory has chosen to offer the populations/individuals in the early option group who are exempt from mandatory enrollment in the benchmark benefit plan the option to voluntarily enroll in the benchmark benefit plan. Please specify whether the benchmark will cover these individuals Statewide/Territory-wide or otherwise.

☐ (ii) When offering voluntary enrollment in a benchmark/benchmark-equivalent benefit plan to exempt populations, prior to enrollment the State/Territory assures it will:

- Effectively inform the individual that enrollment is voluntary, the individual may disenroll at any time and regain immediate access to full standard State/Territory plan coverage, and has described the process for disenrolling.

- Inform the individual of the benefits available under the benchmark/benchmark-equivalent benefit plan, the costs of the package and has provided a comparison of how the benchmark plan differs from the standard State/Territory plan benefits.

- Document in the exempt individual's eligibility file that:
  - The individual was informed in accordance with this section prior to enrollment,
  - The individual was given ample time to arrive at an informed choice,
  - The individual voluntarily and affirmatively chose to enroll in the benchmark/benchmark-equivalent plan.

- For individuals the State/Territory determines have become exempt from enrollment in a benchmark/benchmark-equivalent plan, the State/Territory must inform the individual they are now exempt and the State/Territory must comply with all requirements related to voluntary enrollment. Please describe below the process the State/Territory will use to comply with this requirement.

- The State/Territory will promptly process all requests made by exempt individuals for disenrollment from the benchmark/benchmark-equivalent plan and has in place a process that ensures exempt individuals have access to all standard State/Territory plan services while the disenrollment request is being processed.

- The State/Territory will maintain data that tracks the total number of individuals that have voluntarily enrolled in a benchmark/benchmark-equivalent plan and the total number who have disenrolled.

- For populations/individuals (checked above in 1a. & 1b.) who voluntarily enroll, describe below the manner in which the State/Territory will inform each individual that:
  - Enrollment is voluntary;
  - Each individual may choose at any time not to participate in an alternative benefit package and;
  - Each individual can regain at any time immediate enrollment in the standard full Medicaid program under the State/Territory plan.

2. Description of the Benefits

X The State/Territory will provide the following alternative benefit package (check the one that applies).

a) X☐ Benchmark Benefits

☐ **FEHBP-equivalent Health Insurance Coverage** – The standard Blue Cross/Blue Shield preferred provider option services benefit plan, described in and offered under section 8903(l) of Title 5, United States Code.

☐ **State/Territory Employee Coverage** – A health benefits coverage plan that is offered and generally available to State/Territory employees within the State/Territory involved.

Please provide below either a World Wide Web URL (Uniform Resource Locator) link to the State/Territory's Employee Benefit Package or insert a copy of the entire State/Territory Employee Benefit Package.

☐ **Coverage Offered Through a Commercial Health Maintenance Organization (HMO)** – The health insurance plan that is offered by an HMO (as defined in section 2791(b)(3) of the Public Health Service Act), and that has the largest insured commercial, non-Medicaid enrollment of such plans within the State/Territory involved.

☐The State/Territory assures that it complies with all Managed Care regulations at 43 CFR §438

Please provide below either a World Wide Web URL link to the HMO's benefit package or insert a copy of the entire HMO's benefit package.

X☐ **Secretary-approved Coverage** – Any other health benefits coverage that the

Secretary determines provides appropriate coverage for the population served. Provide below a full description of the benefits in the plan, including any applicable limitations. Also include a benefit by benefit comparison to services in the State/Territory plan or to services in any of the three Benchmark plans above.

The plan includes all benefits under the BadgerCare Plus Standard Plan and the additional services listed in "c" (Additional Benefits), focused on the specific needs of adult members with multiple chronic conditions. A key component is health care coordination, including: (a) medical care plan development that addresses physical needs; (b) service coordination; (c) tracking of service delivery; and (d) service evaluation. The intention is to link members with identified health needs to services and resources in a coordinated effort to ensure the achievement of desired health outcomes and the effectiveness of health and related healthcare services. The medical care will be member centered, trauma informed, and evidence-based. Service provision will include open and flexible scheduling.

1. Benefits will be provided under a medical home framework that includes the following:

    a. Assignment of a primary care physician that meets the requirements for assessing and treating needs common to patients with multiple chronic conditions;
    b. Coordination of health care through a multidisciplinary team, including the primary care physician that works to identify and meet the medical needs of patients with multiple chronic conditions. The team identifies the health needs of each member, creates a care plan, and ensures that each member is assigned a care coordinator;
    c. Follow up by the Care Coordinator on referrals and on linkages between acute care (including emergency room visits), institutional care, chronic care and other specialty care;
    d. Services provided through open and flexible scheduling;
    e. Electronic care plan and communication between, at a minimum, the primary care physician and the Care Coordinator.

2. This medical home framework, with its emphasis on the unique needs of members with multiple chronic conditions and on comprehensive care coordination, will assure a member-centric focus and continuity of care. Members will not be limited in their choice of service providers; however, the care manager will collaborate with the member to identify providers who are experienced in meeting the needs of this population.

Note: For a summary of benefits under this Medical Home Initiative and the Badger Care Plus Standard plan, see Attachment 1.

b) ☐ Benchmark-Equivalent Benefits.

Please specify below which benchmark plan or plans this benefit package is equivalent to:

(i) Inclusion of Required Services – The State/Territory assures the alternative benefit plan includes coverage of the following categories of services: (Check all that apply).

Inpatient and outpatient hospital services;

Physicians' surgical and medical services;

Laboratory and x-ray services;

Coverage of prescription drugs

Mental health services

Well-baby and well-child care services as defined by the State/Territory, including age- appropriate immunizations in accordance with the Advisory Committee on Immunization Practices;

Emergency services

Family planning services and supplies

(ii) Additional services

Please list the additional services being provided.

Please insert below a full description of the benefits in the plan including any additional services and limitations.

(iii) The State/Territory assures that the benefit package has been determined to have an aggregate actuarial value equivalent to the specified benchmark plan in an actuarial report that:

- Has been prepared by an individual who is a member of the American Academy of Actuaries;
- Using generally accepted actuarial principles and methodologies;
- Using a standardized set of utilization and price factors;
- Using a standardized population that is representative of the population being served;
- Applying the same principles and factors in comparing the value of different coverage (or categories of services) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and
- Takes into account the ability of a State/Territory to reduce benefits by taking into account the increase in actuarial value of benefits coverage without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used and taking into account the ability of the State/Territory to reduce benefits by considering the increase in actuarial value of health benefits coverage offered under the State/Territory plan that results from the limitations on cost sharing (with the exception of premiums) under that coverage.

(iv) The State/Territory assures that if the benchmark plan used by the State/Territory for purposes of comparison in establishing the aggregate value of the benchmark-equivalent package includes any of the following two categories of services, the actuarial value of the coverage for each of these categories of services in the benchmark-equivalent coverage package is at least 75 % of the actuarial value of the coverage for that

category of service in the benchmark plan used for comparison by the State/Territory:

- Vision services, and/or
- Hearing services

Please insert below a description of the categories of benefits included and the actuarial value of the category as a percentage of the actuarial value of the coverage for the category of services included in the benchmark benefit plan.

c) x☐ Additional Benefits
If checked please insert a full description of the additional benefits including any limitations.

Persons receive SSI Medicaid coverage if they meet the federal eligibility criteria of being either elderly, blind or disabled and meet income qualifications. Many SSI-eligible Medicaid members receive care in a managed care environment through the Department's SSI Medicaid HMO contracts; however, there continues to be a population of members who receive care on a fee-for-service basis. This population, along with a small subset of BadgerCare Plus members, is receiving medical care on a fee-for-service basis that is often fragmented, with very little overall care coordination. The combination of multiple chronic conditions and poor care coordination has lead to suboptimal health outcomes for individual members and increased costs to the Medicaid program. This plan provides an outline of the care coordination process and enhanced services for members with multiple chronic conditions (excluding mental health comorbidities) in the designated pilot area. The plan includes all benefits under the BadgerCare Plus Standard Plan and adds the following services in an effort to address the unique and ongoing needs of this high risk population:

- A medical home framework specific to adult members with multiple chronic conditions;
- Comprehensive medical assessment and treatment based on best practices and the needs of each member;
- Referral for a comprehensive medication therapy management review by a qualified pharmacist to increase adherence for medication use;
- Enhanced patient education to include:
  - Self-management
  - Health education services
  - Nutritional counseling from dieticians
- Any additional care coordination services needed to address the complex needs associated with this population.

3. Service Delivery System

Check all that apply.

The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements of section 1902(a) and implementing regulations relating to payment and beneficiary free choice of provider. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided on a fee-for-service basis consistent with the requirements cited above, except that it will be operated with a primary care case management system consistent

with section 1905(a)(25) and 1905(t). (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology.)

☐ The alternative benefit plan will be provided through a managed care organization consistent with applicable managed care requirements (42 CFR §438, 1903(m), and 1932).

X ☐ The alternative benefit plan will be provided through PIHPs (Pre-paid Inpatient Health Plan) consistent with 42 CFR §438.

☐ The alternative benefit plan will be provided through PAHPs (Pre-paid Ambulatory Health Plan).

☐ The alternative benefit plan will be provided through a combination of the methods described above. Please describe how this will be accomplished. (Attachment 4.19-B must be completed to indicate fee-for-service reimbursement methodology when applicable.)

4. Employer Sponsored Insurance

☐ The alternative benefit plan is provided in full or in part through premiums paid for an employer sponsored health plan.

5. Assurances

X The State/Territory assures EPSDT services will be provided to individuals under 21 years old who are covered under the State/Territory Plan under section 1902(a)(10)(A).

☐ Through Benchmark only

X As an Additional benefit under section 1937 of the Act

X The State/Territory assures that individuals will have access to Rural Health Clinic (RHC) services and Federally Qualified Health Center (FQHC) services as defined in subparagraphs (B) and (C) of section 1905(a)(2).

X The State/Territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Act.

X The State/Territory assures transportation (emergency and non-emergency) for individuals enrolled in an alternative benefit plan. Please describe how and under which authority(s) transportation is assured for these beneficiaries.

Transportation is assured as under the BadgerCare Plus Standard Plan.

X The State/Territory assures that family planning services and supplies are covered for individuals of child-bearing age.

6. Economy and Efficiency of Plans

X The State/Territory assures that alternative benefit coverage is provided in accordance with Federal upper payment limits procurement requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

7. Compliance with the Law

X The State/Territory will continue to comply with all other provisions of the Social Security Act in the administration of the State/Territory plan under this title.

8. Implementation Date

X The State/Territory will implement this State/Territory Plan amendment on January 1, 2012 *(date).*

Attachment 1: Covered Services — Medicaid and BadgerCare Plus Standard Plan

BadgerCare Plus Medicaid and Standard Plan cover the following services:

- Case management services
- Chiropractic services
- Dental services
- Emergency services
- Family planning services and supplies
- HealthCheck (Early and Periodic Screening, Diagnosis and Treatment - EPSDT) for people under 21 years of age.
- Some home and community-based services
- Home health services or nursing services if a home health agency is unavailable
- Hospice care
- Inpatient hospital services other than services in an institution for mental disease
- Inpatient hospital, skilled nursing facility, and intermediate care facility services for patients in institutions for mental disease who are:
    - Under 21 years of age
    - Under 22 years of age and was getting services when you turned 21 years of age
    - 65 years of age or older
- Intermediate care facility services, other than services at an institution for mental disease
- Laboratory and X-ray services
- Medical supplies and equipment
- Mental health and medical day treatment
- Mental health and psychosocial rehabilitative services, including case management services, provided by staff of a certified community support program

- Nurse midwife services
- Nursing services, including services performed by a nurse practitioner
- Optometric/optical services, including eye glasses
- Outpatient hospital services
- Personal care services
- Physical and occupational therapy
- Physician services
- Podiatry services
- Prenatal care coordination for women with high-risk pregnancies
- Prescription drugs and over-the-counter drugs
- Respiratory care services for ventilator-dependent individuals
- Rural health clinic services
- Skilled nursing home services other than in an institution for mental disease
- Smoking cessation treatment
- Speech, hearing, and language disorder services
- Substance abuse (alcohol and other drug abuse) services
- Transportation to obtain medical care
- Tuberculosis (TB) services